PREVENTION AND EARLY INTERVENTION TRAINING

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DISPARITIES: RACE/ETHNICITY AND GENDER
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California Women's Mental Health Policy Council: WMHPC consists of leaders in women's mental health from around the state. Begun in 1999, the WMHPC advocates for gender sensitive mental health services. The WMHPC mission is to ensure effective, gender-specific culturally appropriate mental health services for women and girls. Our methods include training providers, consumers and family members; researching data sets and evidence-based practices to develop policy and practice reports; and advocating with other statewide partners to promote effective and promising multicultural women's mental health policies and practices. Some of our research on gender disparities is summarized below.

Gender Matters in Mental Health: An Examination of Gender-Based Data
Pat Jordan, M.S.W., February 2004

- Depressive disorders afflict more women (12.0%) than men (6.6%) each year.
- Major depressive disorders afflict more women (6.5%) than men (3.3%) each year.
- Twice as many women as men suffer from panic disorder, post traumatic stress disorder (PTSD), generalized anxiety disorder, agoraphobia and specific phobia.
- Almost equal numbers of women and men have obsessive-compulsive disorder and social phobia.
- Women are much more likely than men to develop an eating disorder. An estimated 85%-95% of people with anorexia or bulimia are female. These two disorders affect approximately 2% of adolescent girls.
- Research with single female heads of household/TANF recipients found that overall prevalence of any of five mental health diagnoses (major depression, generalized anxiety, PTSD, panic disorder or any of several specific phobias) was 38%. 26% had serious mental health problems. 10% had serious difficulties in at least two of mental illness, domestic violence and serious alcohol or drug problems.

Overall, poor women (under 200% of poverty) access public mental health services (through Medi-Cal or the indigent mental health system) less often than poor men. 5.82% of eligible men access services; 5.02% of eligible women access services. This difference is especially pronounced with children and youth: 5.41% of poor boys age 0-17 access care; 3.50% of poor girls access care. Poor men and women aged 18-64 access care in roughly equal proportions; older poor women (age 65+) are more likely to receive care than older poor women. However, older Californians access public mental health care in very small numbers altogether (less than 2%).

Within the Medi-Cal program, the comparatively low rate of access for females continues through age 39. This is of special concern because rates of serious depression in women are highest during the child-bearing years (double that of men); it appears that women are not accessing mental health care at the most critical time in their childrearing responsibilities.

An examination of the percentages of females versus males served in the public mental health system by race/ethnicity must be considered with care, as some numbers are very small. However, there appear to be distinctions. Among Caucasians, men and women access services equally. Among Hispanic and African-American populations, the percentage of females utilizing services is smaller. Other ethnic groups generally find women served more frequently than men, although numbers are so small as to be unreliable. More study of gender differences by ethnicity are needed.

Girls and Juvenile Justice Systems

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- Although boys are more likely to be involved in the justice system, the percentage of girls is rising, and girls are being arrested at a younger age and for more violent activities than at any time in our history. Females are typically incarcerated in the justice systems for longer periods of time than males.
- Girls in the juvenile justice system are likely to have some or all of the following characteristics: member of an ethnic minority group, poor academic history, high school drop out, physically and/or sexually abused and exploited, user/abuser of substances, unmet medical and mental health needs, lacking hope for the future. Females are more likely than males to have a psychiatric disorder.

Conclusions on Prevention and Early Intervention

- For under-represented groups, including girls, young women and women of child-rearing age, first priority should be given to addressing secondary prevention (prevention of recurrences or exacerbations of a disease) and tertiary prevention (reduction in the amount of disability caused by a disease). When the system can be fully developed, attention should be expanded to include primary prevention (prevention of disease before it occurs).
- Access is central to any discussion of barriers to care. Strategies that identify barriers, test strategies to expand access, and promulgate the results should be identified. Transition age young women have specific risk and protective factors for most mental health conditions, and differing developmental adaptations: these must be addressed if the system is to serve all Californians fairly. Women of child-rearing age have time constraints and specific fears and concerns about the impact of identification and treatment on their custody of children. Programs must be tested that address these concerns and service needs.

- Data is limited on the unique issues and challenges for women in ethnic and cultural subgroups. Identification of evidence-based and promising practices to serve these subgroups will be important to access and prevention.
- Trauma is an overwhelming co-occurring experience for girls and women with mental illness. Promulgation of effective access and screening tools to identify trauma exposure should be a key goal.
- Primary care settings serve girls and women with greater frequency than mental health settings, and often with less stigma. Workable protocols for collaborative identification and assessment, and possibly treatment, would provide access and early treatment for girls and women.
- Public information and education and stigma reduction efforts, including targeted work with community agencies, schools and primary care providers, will begin to address access and service issues for girls and women, and other under-served groups.
- The Community Services and Supports portion of MHSA has done a good job of identifying current service delivery by gender and other identifiers. Implementation must focus on providing timely information on the success of both CSS and Prevention and Early Intervention efforts to address unserved and underserved groups. Data must be developed that allows the tracking of age subgroups (such as transition age youth) and the parenting status of consumers of the system.